

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>005099</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>12/16/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>COLUMBUS REGIONAL HOSPITAL</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2400 E 17TH ST COLUMBUS, IN 47201</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for the investigation of one (1) State licensure complaint.</p> <p>Date of survey: 12/16/14</p> <p>Facility number: 005099</p> <p>Complaint number: IN00158408 Unsubstantiated; Lack of sufficient evidence.</p> <p>Surveyor: Marcia Anness RN Public Health Nurse Surveyor</p> <p>Columbus Regional Hospital is in compliance with 410 IAC 15-1.5-2, Infection Control, Hospital Licensure Rules.</p> <p>QA: claughlin 02/18/15</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE